determine if the provider continues to be under intensified review. The contractor performs all other adjudication procedures as part of its regular claims process. The contractor reports the preadmission approved completed claim to the PRO in accord with the provisions of ADP Manual, Chapter 10.

2. General Benefit Requirements

a. Authorization is required before benefits may be extended for care in psychiatric residential treatment centers; for more than sixty (60) days of psychiatric inpatient care in a year; adjunctive dental care and for all care under the Program for Persons with Disabilities. The contractor processes all requests for such authorization from beneficiaries residing within its jurisdiction. Because of the high risk that many services requiring special authorization may be denied, the contractor is required to offer preauthorization for the care to all TRICARE beneficiaries who reside within its jurisdiction.

b. The contractor will issue notification of preauthorization/authorization or waiver to the beneficiary or parent/guardian of a minor or incompetent, the provider, and to its claims processing staff. Notification may be by letter, or on a form developed by the contractor. Authorizations previously issued by TMA continue to be effective. For the purposes of this manual, these forms and letters are all referred to as *TRICARE* authorization forms.

c. Contractors must maintain an automated authorization file or an automated system of flagging to ensure claims are processed consistent with authorizations. Authorization data or flags must be posted and/or set within five (5) work days of issue of the authorization. Contractors shall verify that the beneficiary, sponsor, provider, and service or supply information submitted on the claim are consistent with that authorized and that the care was accomplished within the authorized time period.

d. Contractors shall develop claims containing information which is inconsistent with the authorization and may deny claims for care provided outside the authorization period. Therapeutic absences for a residential treatment center patient will be denied if not authorized by the contractor. For payment to be made for care outside the authorization period, a new authorization must be obtained.

e. If a claim for the types of care in Section IV.H.2.a., above, is submitted without a copy of the authorization and a copy is not on file, the contractor should deny the claim. Advise the beneficiary that a retroactive authorization will be considered. Explain requirements, either in the letter or in a printed sheet or sheets. Provide any necessary forms. No otherwise covered care shall be denied solely on the basis that the authorization was not requested in advance, except care provided by an in-system provider. If the contractor chooses to place added authorization/preauthorization controls on in-system providers, it may do so. However, the TRICARE beneficiary must be "held harmless" in cases where the in-system provider fails to request authorization for care and the contractor denies payment, unless the beneficiary makes an informed decision to receive and pay for the care which has not been pre-authorized.

f. In those instances where a contractor offers voluntary authorization of services in addition to those listed above, such authorization must be available to and appealable by all beneficiaries, whether enrolled or not.

3. Hospice Programs

Network hospice providers must seek prior authorization from the Health Care Finder (HCF) for each election period (refer to Policy Manual, Chapter 13, Section 22.1C for detailed information on election process) unless the care is continuous throughout the subsequent election periods as long as the TRICARE beneficiary remains in the care of the hospice and does not revoke the election.

4. Psychiatric Residential Treatment Centers

a. Care in psychiatric residential treatment centers (RTCs) must be authorized by the Contractor before any payment is made. Claims for authorized admissions occurring before December 1, 1988, shall continue to be paid according to rates in effect for RTC care under the contract at the time of admission until discharge, transfer, or until the care is determined to be no longer medically necessary. For such admissions, professional charges for mental health services may continue to be billed separately and paid by the contractor until discharge. Refer to Policy Manual, Chapter 13, Section 8.1, for grandfathering provisions. Effective for all admissions occurring on or after December 1, 1988, the TMA-determined rate shall apply to any out-of-region beneficiaries who are admitted to the facility.

NOTE:

Effective for all admissions on or after December 1, 1988, to out-of-system RTCs, the first three days of each approved therapeutic absence will be allowed at 100 percent of the TRICARE all-inclusive rate. For in-system RTCs, payment for such absences will be in accord with the contractor-negotiated agreement. All therapeutic absences, educational services, and geographically distant family therapy, must be specifically authorized by the contractor and listed on the contractor-issued authorization form and separately identified on the claim form with dates. (Refer to the Policy Manual, Chapter 13.)

b. Before any claims for residential treatment center care can be paid, an authorization must be on file. The dates of service on the claim form and the name of the facility plus the Employer Identification Number (EIN) with suffix must correspond with the dates of the approval and the facility indicated on the authorization. If the beneficiary resides outside of the contractor's region, the contractor responsible for payment shall pay the claims at the rate determined by TMA. When the contractor issues an RTC authorization, it shall flag its files to preclude payment of any family or collateral therapy that is billed in the name of the residential treatment center patient. That cost is the responsibility of the residential treatment center, unless, as part of its negotiated agreement, the Contractor agrees to a separate payment for such care. Under the TMA-determined rates, family therapists may bill separately from the residential treatment center (outside the all-inclusive rate) only if the therapy is provided to one or both of the parents residing a significant distance from the RTC. In the case of residents of a region, geographically distant family therapy must be certified by the contractor in order for cost-sharing to occur. In the case of residents of a non-MCS region, the authorization must be issued by the TMA mental health review contractor.

c. If an admission is approved, the initial authorization will be for thirty (30) days. At the end of the initial 30 days, the contractor shall review the RTC

treatment plan to determine whether the care continues to be appropriate and to meet all requirements for coverage. If the treatment plan is approved, the case may be approved for up to a maximum of three months. Thereafter, the review will be repeated not less often than every ninety (90) days.

d. If a claim for admission or extension is submitted and no authorization form is on file, the claim shall not be paid. Contractors shall not pay claims for continuing care without a valid authorization on file. For in-system claims, the contractor may deny or develop in accordance with its agreements with in-system providers. For out-of-system claims, the contractor shall develop for the authorization. (See Section VI.H.3.d.(22)(c), regarding the denial message.)

e. For any claims submitted for inpatient care at other than the residential treatment center, the contractor shall pay the claim if the care was medically necessary. Claims for RTC care during the period of time the beneficiary was receiving care from another inpatient facility shall be denied. If the residential treatment center has been paid and a claim for inpatient hospital care is received and the care was medically necessary, the contractor must pay the inpatient hospital claim and recover the payment from the residential treatment center according to the provisions in OPM Part Two, Chapter 5.

f. For cost-sharing determinations, the TMA-determined rate or the contractor's negotiated rate, whichever is more favorable to the beneficiary, is to be considered the TRICARE allowable charge. The total per diem rate billed by the residential treatment center shall not exceed the per diem rate stated in the addendum to the RTC participation agreement, except in the case of an in-system RTC paid under a contractor-negotiated rate. In addition, for out-of-system RTCs, therapeutic absences will be listed on the claim form and for any greater than three (3) days, the days in excess of the first three will be reimbursed at 75 percent of the TMA-determined rate. This results in therapeutic absences of greater than three (3) days being reported as two EOB line items, i.e., the first three (3) days paid at 100 percent of the TMA-determined rate and the remainder reduced to 75 percent. For in-system RTCs, reimbursement for therapeutic absences will be in accordance with Contractor-negotiated agreements. (See the ADP Manual, OCHAMPUS 6010.50-M, for reporting requirements on RTC therapeutic absences.) All other separate mental health charges submitted by the residential treatment center or by any other mental health providers shall be denied except for geographically distant family therapy and educational costs which have been reviewed and specifically authorized by the contractor. All nonresidential treatment center claims submitted for outpatient **non-mental health** services shall be reviewed and, if determined to be medically necessary, shall be processed for payment.

g. For the first claim received from the residential treatment center, the contractor shall review the beneficiary's history back to the admission date or the date of the participation agreement, whichever is later. All payments made to other mental health providers for services rendered during the same period as the residential treatment center care shall be recovered as an overpayment unless allowed as part of an in-system negotiated agreement. (See OPM Part Two, Chapter 5.) The contractor shall ensure that adequate safeguards exist to prevent unauthorized payment of nonresidential treatment center mental health claims. (Refer to the Section VI.H.3.d.(22)(c), for the EOB denial message.)

5. Dissemination of Information on Authorization Requirement under the Basic Program

a. General

The contractor is required to advise beneficiaries, sponsors, providers, and other responsible persons of those benefits requiring authorization before payment can be made and of the procedures for requesting this authorization. Although beneficiaries are required to obtain authorization prior to receiving payment for the care listed in Section IV.H.2.a., above, authorization may be requested following the care. Whether the authorization is requested before or after care, all qualified care shall be authorized for payment. Contractors shall emphasize the need for concerned persons to contact their health benefits advisor or the Health Care Finder for assistance.

b. Information Required for Authorization Determinations

The *contractor shall document authorization according to current contract requirements.*

6. Authorization for Grandfathered Custodial Care Cases

A list of the beneficiaries who qualified for custodial care benefits prior to June 1, 1977, has been furnished to each contractor with instructions to flag the file for those beneficiaries on the list who are within their region. Claims received for those beneficiaries, for which no authorization is on file, are to be suspended and the contractor to notify the TMA, Benefit Services Branch. Refer to the 32 CFR 199.4.

7. Payment Reduction

During claims processing, provider payments shall be reduced for failure to comply with the preauthorization requirements for certain types of care. See the Policy Manual, Chapter 13, Section 24.1, and OPM Part Two, Chapter 4, Section IV. and OPM Part Two, Chapter 17, Section II. and Section III.

I. Ambulatory Surgical Centers

Refer to the Policy Manual, Chapter 11, Section 2.1, 11.3, and Chapter 13, Section 9.1, for cost-share, itemization and nonavailability statement provisions, facility certification requirements and reimbursement procedures.

J. Medical Review

1. Requirements for Compliance

The Public Law 89-614 and amendments governing the operation of CHAMPUS; Chapter 55, Title 10 of the United States Code, require reimbursement of eligible TRICARE beneficiaries and providers for covered services that are medically necessary.

2. Medical Necessity Defined

"Medically necessary" means the level of service and supplies; i.e., frequency, extent, and kinds, adequate for proper diagnosis and treatment of illness or

injury, including maternity, well-baby, and mental health care. Medically necessary includes the concept of the appropriateness of medical care.

3. Benefit Policy Decisions

a. TRICARE Versus Local Policy

TRICARE policies have precedence over any local or internal policy of the contractor or the medical community of the region where non-Prime enrollees are involved. However, the contractor shall notify TMA promptly of any conflicts between TRICARE policy and local policy. For TRICARE Prime enrollees, variations from policy which simply expand coverage may be implemented without prior approval, but TRICARE must be notified of enhanced coverage at least 30 days prior to implementation. If benefits are being reduced or adjusted, the change shall be referred to TMA for approval before being implemented.

b. TRICARE Policy Silent

When TRICARE is silent on an issue, the matter shall be referred to TMA for a benefit policy determination. Until a policy is published by TMA covering the specific issue, all claims involving the policy issue must be denied. The policy issuance from TMA will include specific instructions for handling claims when a retroactive determination is made. If the policy determination affects procedures for claims processing, an Operations Manual change will also be issued.

4. Levels of Claims Review

a. Contractor First Level Claims Review

At the first level review, basic prepayment screens (automated and manual), are applied to each claim submitted. Such prepayment screens shall include, but not be limited to, the following:

(1) Screening of the claim against the series of diagnoses and related procedure codes which are specific exclusions or limitations of the Program.

(2) Screening of the claim for possible duplicate care and billings. (Refer to Section VI.D. of this chapter.)

(3) Screening of the claim for unusual dollar amounts for a claimed service or supply. (Refer to Section VI.B.5. of this chapter.)

(4) Screening of the claim for appropriate length of stay to diagnosis parameters on inpatient care.

(5) Screening of the claim for excessive utilization of services, supplies, or pharmaceuticals.

(6) Referring any unresolved medical necessity questions of the initial review personnel to medical review personnel.

b. Medical Review

Medical Review must be carried out by registered nurses, or equally qualified medically trained staff, who can make medical judgments based on

professional education and experience. This means RNs or qualified Physician's Assistants (PAs), for medical claims; for handling of mental health claims, an RN or PA with mental health training, or a qualified MSW or clinical psychologist. A qualified, graduate pharmacist may be used for prescription drug claims. A qualified LVN, working directly under the close supervision of an RN or PA, may be used, if the contractor submits the LVN's full resume and a detailed scope of authority and responsibility to the Contracting Officer's representative for approval before the LVN assumes a medical review role. These personnel must have a thorough knowledge of medical policy, standards and TRICARE criteria. The contractor shall make documented guidelines available to reviewers for all coverage parameters and medical necessity criteria. The reviewer shall document the rationale for the approval or denial of coverage; i.e., fully state the evidence and the reasons that were the basis for approval or denial. The review must be dated and include the clinical specialty of the reviewer (e.g., R.N., L.P.N.) and the signature and legibly printed name of the reviewer (not initials). Contractors with fully documented guidelines may desire to standardize phraseology for common procedures and recurring types of cases. This is acceptable if the record supports the conclusions that were made. If the initial review personnel cannot make a determination, the claim(s) shall be referred to Medical Review. Either contractor medical staff or an external consultant shall do the review. Use of medical staff and/or consultants is expected and required for not only initial claims processing, but also in appeals or in postpayment analyses. Whenever the case is complex, physician consultants, with a specialty which is appropriate to the case, should be involved in the review. In the case of mental health claims, a staff or consultant physician must be involved in complex cases and in all mental health case appeals. The physician consultant will carefully review the case and document the rationale for the decision; i.e., fully state the evidence and the reasons that were the basis for approval of denial. The review must be dated and include the clinical specialty of the reviewer (e.g., M.D., D.O.) and signature and legibly printed name of the reviewer. The physician reviewer must document his or her rationale for the approval or denial of coverage in a brief written opinion in the case file. The opinion must be signed (not initialed) by the reviewer. To expedite out-of-system claims processing and to make more effective use of physician medical advisors, telephone consultations with the advisor may be used if the following provisions are met:

(1) The consultation must be handled by a supervisory level registered nurse medical reviewer or by a physician member of the contractor's advisory staff.

(2) There must be great care taken to prevent misunderstanding of the circumstances of the case and the medical advisor's recommendations.

(3) The matters discussed and the recommendation must be thoroughly documented, including the date, the rationale for the decision/recommendation, the name of the caller and the name of the medical advisor.

(4) The medical advisor who was contacted must review the actual case file and countersign the written decision within ten (10) workdays of the call. The case should not be delayed for the signature.

(5) The use of telephone calls must not be used to replace in-person medical advisor reviews, but to supplement them and to increase the ability to speed

processing and to increase involvement of appropriate specialists in effective review of complex cases.

5. Abortion Services

a. TRICARE Claims Review and Processing Procedures

(1) Processing

Contractors shall process all claims for abortion services/supplies (including claims for consultation services) in accordance with the Policy Manual, Chapter 3, Section 13.6. Automated prepayment edits are required for induced abortion procedures.

(2) Denial of Payment

When a service(s) is denied due to an abortion, a letter of explanation shall be sent, but only when the denial is questioned by the beneficiary. Figure 2-1-A-12 provides suggested wording for abortion claims that are denied. **The explanation shall be provided only to the beneficiary and participating provider**. The special denial letter shall be sent in an envelope marked "personal". **It is EMPHASIZED that using** a TRICARE **Explanation of Benefits is NOT acceptable for denial of abortion services**. Only an approved letter may be used.

b. Request for Reconsideration

Refer to the OPM Part Two, Chapter 6, **Appeals and Hearings,** for processing reconsiderations.

c. Processed Claim Records: Abortion Services and Supplies

The contractor shall be able to retrieve the hard copy of all processed claims for abortion services and supplies, whether paid or denied, upon request by TMA. Such recovery must be completed within fifteen (15) workdays of receipt of such request.

6. Liver Transplant Claims

Benefits are payable for liver transplantation when the service meets the requirements specified in the Policy Manual, Chapter 3, Section 8.5. (Provider and reimbursement requirements are also included in the Policy Manual.)

7. Heart Transplant Claims

Benefits are payable for heart transplantation when the service meets the requirements specified in the Policy Manual, Chapter 3, Section 5.3. (Provider and reimbursement requirements are also included in the Policy Manual.)

8. Birthing Centers Claims

Refer to the Policy Manual, Chapter 1, Section 7.1, (related emergency services) and Chapter 6, Section 6.1 (hospital-based birthing rooms); Chapter 10,

Section 1.3, (birthing centers); Chapter 10, Section 1.3 (professional services and cost-share); and Chapter 11, Section 11.2 (provider certification process).

9. Hospice Claims

Benefits are payable for hospice care when the services meet the requirements specified in the Policy Manual, Chapter 13, Section 22.1D. (Provider and reimbursement requirements are included in this section.)

children as well as different types of former spouses. Sample relationship downloading logic appears in the ADP Manual, Chapter 9, Section IV.C.7.

f. Patient's Identification Card Information

TRICARE claims require ID card information only if the patient is not on DEERS and the claim is payable under the guidelines in the ADP Manual, Chapter 9.

g. Sponsor's Full Name

The sponsor's last name and first name must be present on each claim. Develop if the sponsor's name is incomplete, discrepant, or missing or an initial or nickname is used.

NOTE:

For purposes of TRICARE claims submitted by eligible former spouses, "Sponsor" is to be the member or former member.)

h. Sponsor's Social Security Number

The sponsor's Social Security Number must be present on each claim (except NATO members and family members of active duty Security Agents). The SSN which appears on DEERS shall be used for claims processing, history, EOB and HCSR reporting purposes, unless it can be proven to be erroneous. Do not override DEERS in the absence of clear and convincing evidence (such as copies of social security cards, orders, ID cards, etc.) that the information which appears on DEERS is incorrect. The sponsor's service number is acceptable in those cases in which a social security number was never obtained/ issued. If a participating provider's claim is received with no SSN, the contractor shall telephone the provider for the SSN. If a nonparticipating claim lacking the SSN contains the beneficiary's telephone number, the contractor shall call the beneficiary to obtain the SSN. If the SSN is not obtainable by telephonic development or from history, the contractor is to return the claim uncontrolled with an explanation of the reason it is being returned, e.g., the sponsor's SSN must be provided in order to process a claim. If a sponsor is a NATO member, NATO shall be entered on the claim along with a copy of the family member's ID card. If the sponsor is an active duty Security Agent, and is restricted from furnishing his/ her SSN, "Security" should be entered on the claim and family members must attach a copy of their ID card with the claim. Control develop if this information is incomplete, discrepant, or missing, i.e., for NATO electronic media claims (EMC) the copy of the family member's ID card will not be attached to the claim; therefore, controlled development for the copy of the ID card shall be conducted. For DEERS SSN downloading requirements, refer to the ADP Manual, Chapter 9, Section IV.A.2.b.

i. Sponsor's Grade or Rank

The sponsor's grade or rank is available on DEERS and shall be used to determine the appropriate deductible category for beneficiaries of active duty sponsors, unless there is other evidence indicating that an active duty sponsor's pay grade is different. If a higher pay grade is reported on the claim than appears on DEERS, and has an impact on deductible or cost share, the DEERS value shall be overridden and the higher value used for purposes of claims processing, history and HCSR reporting. If a lower pay grade is reported on the claim than appears on DEERS, and the lower pay grade would make a difference for purposes of applicable deductible, the contractor shall develop for

evidence of the actual pay grade. Otherwise, the pay grade reported on the claim shall be used for purposes of claims processing, history and HCSR reporting. The contractor is provided override authority in the ADP Manual, Chapter 9, Section II.D.9. If the pay grade category used by the contractor is questioned by the beneficiary/sponsor, it is the sponsor/beneficiary's responsibility to prove (ID Card or Service documentation; promotion/demotion papers) that the pay grade/rank is incorrect. For DEERS pay grade downloading requirements, refer to ADP Manual, Chapter 9, Section IV.C.3.

NOTE:

The increase applies to NATO beneficiaries. See Section I.A.5., NOTE 2 for the Desert Shield exemption.

j. Sponsor's Branch of Service

The sponsor's branch of service may or may not be present on each claim, dependent of whether the claim form has space for reporting branch of service. The branch of service which appears on DEERS shall be used for claims processing, history, and HCSR reporting purposes, unless it can be proven to be erroneous. If the branch of service is missing or not reported on the claim form (HCFA-1500 or UB92), and DEERS does not reflect a value which can be used for claims processing, history, and HCSR reporting purposes, development is required. Do not override DEERS in the absence of clear and convincing evidence (such as copies of orders, ID cards, etc.) that the information which appears on DEERS is incorrect. For DEERS branch of service downloading requirements, refer to ADP Manual, Chapter 9, Section IV.A.2.e.(3)

k. Sponsor's Status

The sponsor's status (active duty, retired, deceased) at the time the service was rendered may or may not be present on the claim dependent on whether the claim form has space for reporting sponsor's status. The sponsor status which appears on DEERS shall be used for claims processing, history, and HCSR reporting purposes, unless it can be proven to be erroneous. Do not override DEERS in the absence of clear and convincing evidence (such as copies of retirement orders, ID cards, etc.) that the information which appears on DEERS is incorrect. For DEERS sponsor status downloading requirements, refer to ADP Manual, Chapter 9, Section IV.C.3.

2. Double Coverage Information

A determination regarding other health insurance coverage must be made on all claims. Refer to OPM Part Two, Chapter 3, **Double Coverage**, for information.

3. Work-Related/Military Service-Related/Accident-Related Conditions

If the claim form contains indication that one of the these relationships exists, development is required.

a. Work-Related

When information on the claim form indicates the possibility of liability under Worker's Compensation, the contractor shall develop information to determine TRICARE coverage or referral to Worker's Compensation.

(b) *DD* Form 2520

The TRICARE DD Form 2520 allows a provider to certify the services or supplies rendered by listing them and signing item 33, whether an in-system provider or an out-of-system provider, participating or not. A provider-completed form is adequate documentation. If the DD Form 2520 is not signed (stamped) by the out-of-system provider, a separate itemized bill, receipt, or statement of services or supplies, prepared on the provider's billhead must be attached before the claim may be processed. If itemization is incomplete, discrepant, do not acquire this information from the existing file data, but develop through written request or a documented call, if appropriate. See Section V.B. of this chapter regarding missing itemization. An unsigned provider-completed claim is to be returned uncontrolled to the claimant for the provider's signature or a separate itemized bill on the provider's billhead (nonparticipating claims only). In-system providers will comply with required provisions of the Contractor's agreement and established Contractor/provider administrative procedures.

Note: After December 31, 1995, the DD Form 2520 will no longer be acceptable for TRICARE claims filing except for services in foreign countries.

(c) Exceptions to Itemization Development Requirements for Individual Provider Claims

The tolerances below may be used at the contractor's option. TMA waives its usual requirement for detailed procedure data on health care service records.

1 When the individual provider of care bills for one or more laboratory services under only the general description of laboratory tests or services and the total charge for these services is $50 or less, the line item need not be developed for specific description or procedure. If the diagnosis or description of illness supports the reasonableness of one or more laboratory services being performed in connection with other TRICARE covered services, the charge will be deemed allowable and adjudicated accordingly. If the diagnosis or description of illness does not support the inclusion of one or more TRICARE covered laboratory services, the charges for these services must be denied or developed.

2 When the individual provider of care bills for services in radiology under only the general description of radiology or x-ray and the charge for these services is $75 or less, the line item need not be developed for specific description or procedure. If the diagnosis or description of illness does not support the inclusion of one or more TRICARE covered services in radiology, the charges for these services must be denied or developed.

(4) Prescription Drugs and Medicine (and Insulin)

Contractors shall accept pharmacy receipts (legible photocopies of pharmacy receipts are also acceptable) or prescription listings on pharmacy letterhead, which contain all the information required below.

NOTE:

Outpatient institutional services do not require itemization unless there is reason to question the claim and/or charges.

(a) Minimum Requirements

The following information is required:

1. The name of the patient.
2. The name, strength, and quantity of each drug.
3. Prescription number of each drug, except insulin.
4. The cost of each drug.
5. The date prescription was filled.
6. The name of the prescribing physician.
7. The name of the pharmacy where the drug was purchased.

NOTE:

While not required for HCSRs, many electronic media claims pharmacy systems require the reporting of the Drug Enforcement Administration (DEA) number for controlled substances. To fill controlled substance prescriptions, all prescribers are required to provide this number. For all prescriptions written by MTF providers that are to be honored by civilian pharmacies, the MTF providers will place on the prescription, in addition to the above requirements, the name of the MTF, and the MTF's DEA number followed by a hyphen and a sub-identifying number that is prescriber specific such as the last four digits of the provider's Social Security Number. Contractors are only required to inform their network pharmacies of the requirements for MTF provider controlled substance prescriptions.

NOTE:

Because prescriptions are paid as billed, you may use "Your Pharmacy" on the EOB on non-assigned prescription claims. It is not necessary to develop for the actual name and address of the pharmacy. If the name of the provider is known, the contractor is required to verify that the provider is not sanctioned, excluded or terminated from the TRICARE program prior to adjudication of the claim submitted by either the provider or the beneficiary. Claims for medical supplies or DME purchases from pharmacies are not included in this category. If the beneficiary has a "prepaid prescription plan" in which the beneficiary pays only a "flat-fee" no matter what the actual cost of the drug, the contractor shall costshare the fee and not develop for the actual cost of the drug, since the beneficiary is only liable for the "fee." Refer to Policy Manual, Chapter 13, Section 13.3.

EOB Messages (Continued)	
23	Service included in surgical allowance.
24	Anesthetic by attending physician in surgical allowance.
25	Psychiatric limits exceeded.
26	Physical therapy limit exceeded.
27	Speech therapy limit exceeded.
28	Maximum allowed for ambulance service paid.
29	Authorized service limits exceeded.
30	Charges exceed monthly maximum.
31	Service filed after time limit.
32	Services covered by Workers Compensation.
33	Duplicate of service previously claimed.
34	Nonprescription drug.
35	Noncovered diagnosis.
36	Obesity not a covered diagnosis.
37	Noncovered services.
38	Routine physical not covered.
39	Routine immunization not covered.
40	Routine foot care not covered.
41	Orthopedic shoes not covered.
42	Routine test/lab/x-ray not covered.
43	Outpatient maternity care; Inpatient maternity care may require a Nonavailability Statement. Contact your HBA.
44	Noncovered routine eye examination.
45	Eye glasses/lenses not covered.
46	Eye refraction not covered.
47	Foot supports/orthotics not covered.
48	Chiropractic services not covered.
49	Personal comfort item not covered.

EOB Messages (Continued)	
50	Domiciliary/custodial care not covered.
51	Sponsor not on DEERS.
52	Patient not eligible on DEERS.
53	Reserved
54	ID Card or eligibility expired on DEERS - see back.
55	Requested 3rd party info not received.
56	Charge covered by Residential Treatment Center payment.
57	Charge reduced for therapeutic absence exceeding 3 days.
58	Unauthorized therapeutic absence.
59	Requested third party liability information (DD Form 2527) not received.
60	Home Health Care Authorization not on file.
61	Personal Injury Insurance Payment Information Required.
62	Services rendered or supplies provided are not covered because records submitted do not meet medical documentation requirements.
63	Charges included in ambulance base rate.
64	Payment determined under DRG-based payment system; amount allowed is payment in full. DRG reclassification requests must be made within 60-days of payment.
65	These services must be billed separately.
66	DRG-based payments cannot be made for interim bills.
67	Outlier payments denied due to loss of beneficiary eligibility.
68	Incomplete/inaccurate claim cannot be paid under DRG-based payment system.
69	Not an authorized Partnership provider.
70	No patient liability; cost-shares and deductibles not applicable to Internal Partnership Program.
71	*Reserved*
72	Facility where services rendered not military facility.
73	Catastrophic cap reached, cost-shares and deductibles no longer apply.

EOB Messages (Continued)	
74	Necessity for MRI not documented, paid as CT scan.
75	Charge reduced to established visit.
76	Claim has been split for processing.
77	No separate payment is allowed for incidental procedures.
78	No authorization on file.
79	Services or supplies are not authorized under the Program for Persons with Disabilities.
80	Interim DRG billing submitted out of order.
81	Interim DRG bill outside of dollar parameter.
82	Requirements for medical emergency not met - Nonavailability Statement required.
83	$____.__ has been applied toward the catastrophic cap of $1,000.00.
84	$____.__ has been applied toward the catastrophic cap of $7,500.00.
85	Catastrophic cap met with this claim. Cost-share/deductible reduced accordingly.
86	Charges exceed daily maximum.
87	Payment amount determined under inpatient mental health per diem payment system and is payment in full.
88	Incomplete/Inaccurate claim cannot be paid under TRICARE inpatient mental health per diem payment system.
89	*Reserved*
90	Rehab limits reached. Submit detox services separately.
91	Outlier payments denied due to exceeding the 60-day limit.
92	This service allowed at 50% when performed in conjunction with anesthesia.
93	Payment reduced to negotiated rate(s).
94	Partnership claim denied; agreement has expired.
95	Payment denied for service(s) not included in Partnership agreement; beneficiary not liable - provider should contact MTF.
96	Providers will not collect additional cost-shares for increases in RTC rates, as a result of rebasing.

EOB Messages (Continued)	
97	This service is included in the DRG-based payment; therefore, no additional payment is warranted.
98	Provider not contracted for the services rendered; therefore, your claim is denied.
99	Authorization for Mental Health services must be obtained prior to the seventh outpatient psychotherapy session; therefore, your claim is denied.
100	This statement is informational only and represents a posting to claims history of a previously issued manual payment.
101	Payment includes an additional allowance for blood clotting factor.
102	Insufficient diagnosis.
103	Non covered concurrent care.
104	Inpatient Nonavailability Statement authorization not on DEERS - contact the MTF.
105	Nonavailability Statement Authority no longer valid - Contact the MTF.
106	Services not covered under Cooperative Care Program
107	Outpatient Nonavailability Statement not on DEERS; contact the military treatment facility for assistance.
108	Payment does not include professional service charges; bill separately on the HCFA 1500.
109	Incomplete DD Form 2527 received
110	Level of Care Billed Not Substantiated.
111	Services Denied Due To HMO Coverage or other primary health insurance
112	Preauthorization for this transplant not on file. Contact your contractor at the number listed on this Explanation of Benefits.
113	Does not meet criteria for pre-existing condition.
114	This service is part of a single group of services performed at the same time which TRICARE has paid. If this claim was filed on a participating basis, the beneficiary is not responsible for payment of the disallowed amount.

EOB Messages (Continued)	
115	This amount plus the amount allowed on previous claim(s) for a part of this service performed at the same time is the maximum allowable amount for this service. If this claim was filed on a participating basis, the beneficiary is not responsible for payment of the disallowed amount.
116	Obsolete procedure code(s) submitted; future claims must contain current procedure code(s) or services will be denied.
117	Obsolete procedure code(s) submitted - service(s) denied; provider must provide correct procedure code(s).
118	No Nonavailability Statement for procedure or service performed.
119	These services require prepayment approval. Please call (insert telephone number) for assistance.
120	Provider is not TRICARE authorized. Requested provider certification information not received.
121	Other health insurance information not provided.
122	Consultation paid as limited office visit. Referring physician not identified.
123	Dental condition not a benefit. TRICARE coverage limited to authorized care required due to a medical condition.
124	Dental authorization not on file.
125	Claim *denied as we are no longer processing* CHAMPVA *claims.* (See NOTE, below.)
NOTE: *EOB Message 125 listed above is an abbreviated version of the following message that the contractor shall use when the contractor denies a CHAMPVA claim when the DEERS response indicates a CHAMPVA alternate care flag "V". (See OPM Part Two, Chapter 1, Section IV.A.2.c.). In the absence of system limitations which preclude its use, the longer message must be used:* *"Claim denied as we are not responsible for processing CHAMPVA claims. Please resubmit the claim to: Health Administration Center, CHAMPVA Program, Post Office Box 65024, Denver, CO 80206-9024. Refer any outstanding questions to the CHAMPVA Program at 1-800-733-8387."*	
126	Medical necessity for standby pediatric physician not documented.
127	Charge reimbursed at the intermediate office visit level.

EOB Messages (Continued)	
128	Provider certification status not documented.
129	Checks not issued for amounts of $.99 or less.(See NOTE, Below.)
NOTE: *Only applies to contracts awarded in FY 94 and thereafter.*	
130	Amount allowed is based on a discount agreement.
131	Reserved
132	Partnership claim not correctly submitted.
133	Family member is no longer eligible, contact your nearest military personnel office or your Administering Secretary.
134	General office visit codes are not used for billing eye exam services. Please resubmit with appropriate codes.
135	Claims must be filed by the VA Medical Center.
136	Charge denied; this Durable Medical Equipment is available for loan from a local MTF.
137	Reserved
138	Services rendered by an unauthorized Marriage and Family Therapist. The provider should contact us for information on how to become a TRICARE authorized provider.
139	Unauthorized Provider. Provider is either an active duty member of the Uniformed Services or a civilian employee of the U.S. Government and is prohibited by Regulation from billing TRICARE or TRICARE beneficiaries.
140	Services, supplies, and equipment associated with palliative care of terminal patient included within hospice all-inclusive rate.
141	Services curative in nature and waived as part of the beneficiary's election to receive care under TRICARE hospice benefit.
142	Claim denied due to hospice's failure to submit requested medical documentation within designated time frame (thirty (30) days from request).
143	Reclassification of hospice care to another rate category based on medical review.
144	Hospice reimbursement reduced to routine home care rate for inpatient respite care exceeding five (5) days.
145	Services paid under the ambulatory surgery prospective payment rates.